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Published in:
Sociology of Health and Illness

DOI:
10.1111/1467-9566.13161

Publication date:
2020

Document Version
Peer reviewed version

Citation for published version (APA):
Ernst, J. (2020). Professional boundary struggles in the context of healthcare change: the relational and symbolic constitution of nursing ethos in the space of possible professionalisation. *Sociology of Health and Illness*, *42*(7), 1727 - 1741. https://doi.org/10.1111/1467-9566.13161

Professional boundary struggles in the context of healthcare change: the relational and symbolic constitution of nursing ethos in the space of possible professionalisation

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Abstract

The paper draws on Bourdieu's conceptualization of the symbolic order and his little used concept of ethos in order to gain novel understandings of boundary struggles between nursing and medicine as well as internally in nursing. The constituents of boundary struggles are analysed in the context of healthcare transformation, focusing on organizational, institutional and political boundary undertakings. Changing conditions for boundary demarcations and professionalisation include a preference for evidence-based knowledge and practice, seen as a remedy against common problems in healthcare. The paper shows how nurses use the changes in 'the space of possible professionalisation' in their struggle for professionalization when they expand their scope of practice and embark on what is conceptualised as a curing ethos, where nursing is understood as a discipline performing practices that lead to cure. However, this is repudiated by the medical profession at all levels. Moreover, curing stands opposed to the caring ethos in nursing, and boundary struggles surface as 'ethos confrontation'

between caring and curing oriented nurses in practice. The boundary struggles analysed in this paper raise important questions about healthcare manageability and the development of sustainable professional environments.

Keywords: Boundary struggles, caring and curing, healthcare manageability, professionalisation, nursing ethos, medicine, symbolic order, the space of possible professionalisation

Introduction

The paper concerns how nurses and doctors navigate current transformations in the field of healthcare to either to sustain professional boundaries or claim professionalisation by introducing new boundaries. Professional jurisdictions and boundaries are critical factors in the configuration of healthcare. Accordingly, they are important for the organisation of care and a complex aspect of healthcare planning and management (Abbott, 1988, Currie et al., 2010, Huby et al., 2014, Jones et al., 2019, Kessler and Spilsbury, 2019, Nancarrow and Borthwick, 2005). Moreover, as the paper will show, professional boundaries influence day-to-day professional practice, collaboration and care delivery (Cramer et al., 2018, McMurray, 2011, Salhani and Coulter, 2009).

Healthcare is undergoing steady transformation as a site of political interest and contestation that is influenced by global developments, changing the conditions for professionalisation and transforming work (Jespersen, 2013, Jones et al., 2019, Nancarrow and Borthwick, 2005). Changes particularly involve the construction of new professional categories and flexible work roles to cater for patient-related needs in healthcare organisations. Kessler and Spilsbury (2019) suggest that the development of new work roles is among the most challenging types of healthcare change. However, while professional work and roles as well as opportunities for professionalisation and professional boundaries are under development due to transformations in the

professional environment, this development is concurrently curtailed by the continuous struggle for upholding institutionalised professional boundaries (Currie et al., 2012, McMurray, 2011). Therefore, it becomes interesting to examine the constituents of current boundary struggles and the emergence and development of boundary struggles at different levels of a healthcare system. I wish to forward a focus on organizational, institutional and political boundary enterprises as well as responses to them. Understanding such mechanisms are key for developing a solid foundation for policy and management in healthcare (Kessler and Spilsbury, 2019).

The paper examines recent boundary struggles between the nursing and medical professions as well as internally in nursing in the Danish hospital sector. I follow the call by Evetts (2013) for introducing new theories and concepts in order to expand knowledge on boundary struggles and strengthen our explanatory capacities. The study contributes to theory by using Bourdieu's (1977, 1989) conceptualization of the symbolic order and his little used concept of ethos as embedded in his relational sociology. The relational perspective allows the study to responds to calls for examining the relationship between professions rather than professions in themselves (Cramer et al., 2018, Huby et al., 2014). Additionally, and contrary to an almost exclusive understanding of these struggles as inter-professional phenomena, the paper draws attention to intra-professional boundary dynamics that relate to and may enlarge professional stratification. Boundary dynamics and struggles are thus analysed as a multi-layered phenomenon, where conforming or contradicting beliefs about professions render the professional world real (Schinkel and Noordegraaf, 2011).

The paper contributes on empirical grounds by illuminating how clinical expert knowledge and science increasingly come to structure what I analyse as 'the space of possible professionalisation', inspired by Bourdieu (1996). Thereby, knowledge comes to delineate possible courses of action for the professions, which, in particular, is topical for nursing. The paper shows how nurses embark on new titles,

roles and activities that rely on evidence-based knowledge and a medical orientation towards care – analysed as a curing ethos (Ernst, 2016, Salhani and Coulter, 2009). Curing works as a professionalisation strategy, which is, however, renounced by the medical profession. Moreover, curing causes nursing internal struggles because it stands opposed to the traditional ethos of caring in nursing. It is demonstrated how boundary struggles are fought symbolically and materially i.e. as political discursive action in the media, in day to day work among nurses and in the collaboration between nurses and doctors in a Danish hospital department. The paper discusses the consequences of the current constellation of the space of possible professionalisation for nursing, the relation between medicine and nursing and for healthcare manageability and the development of a sustainable professional environment.

The paper proceeds as follows: I first sketch the dynamics of the healthcare field prompted by societal dynamics that re-define the conditions for professionalisation and boundary demarcations. Then the theoretical framework and methodology used are outlined. After that, I briefly sketch the professional developments of medicine and nursing and how forms of knowledge relate to professionalization. This is followed by the analysis of data. The results of the analysis are further addressed in the discussion and conclusion section, where I suggest five constituents of current boundary struggles in the Danish hospital sector that influence nursing ethos and boundary dynamics.

The current constellation of the field for professional boundary demarcations and struggles

A driving force in the transformation of healthcare that leads to the emergence of a new space of possible professionalisation is ongoing public reform. Simultaneously, neo-liberal managerial principles have gained momentum, rendering healthcare a domain for tightened control (Huby et al., 2014, King et al., 2015, Nancarrow and Borthwick,

2005). New Public Management (NPM) was employed across nations as an overall steering ideology to encompass different tools of performance management, understood as the systematic management and measuring of practices, treatments, individuals and organizations (Jespersen, 2013). Several initiatives have thus been employed in efforts at achieving high quality, safe, efficient, integrated and timely care (Huby et al., 2014, Warwick-Giles and Checkland, 2018). A global development emerged in this atmosphere, where medical evidence-based knowledge is perceived as providing decision makers with a scientific, neutral and objective tool. Evidence-based knowledge is seen as enabling secure decisions in clinical practice and healthcare overall (Broom and Adams, 2012, Timmermans and Kolker, 2004). In addition, evidence-based knowledge facilitates the quantification and standardisation of practice, which narrows down the practitioner's space of manoeuvre and is in keeping with NPM (Jespersen, 2013, Timmermans and Epstein, 2010).

Of importance is also that in Denmark, as elsewhere, a shortage of doctors provides incentives for policy makers to encourage professional flexibility and establish shifts in the division of labour in healthcare (Huby et al., 2014). Initiatives have been launched that focus on the upscaling of nursing competences, enabling them to take over tasks previously belonging to the medical profession (Pinborg, 2017, Tram, 2017); often termed 'task delegation' (Maier et al., 2017, p. 15, Nancarrow and Borthwick, 2005). Task delegation affects the boundary between medical and nursing work and the relation between 'cure' and 'care' (Baumann et al., 1998, Salhani and Coulter, 2009). In summary, the space of possible professionalisation is undergoing change, resulting from a perception of change urgency and an ideological re-orientation of healthcare. In consequence, new professional dynamics and struggles emerge among nurses and doctors as well as internally in nursing as the analysis will show.

A theoretical framework for the analysis of professional struggles

Professions are often seen as the supreme experts of fields of specialization, organising large areas of social domains (McDonald, 2014). The idea of professions rests on a belief in the professions' public claims to jurisdiction, and their constructions of the work they do as positively associated with trustworthiness and credibility. Moreover, belief in professions includes their claims to esoteric knowledge perceived as superior to practical knowledge and not easily replicable (Abbott, 1988, Faulconbridge and Muzio, 2012, McMurray, 2011). From the perspective of Bourdieu's theoretical ideas, profession and professionalisation inherently results from beliefs in difference, power struggles and processes of social construction that render perceived differences between occupational groups 'real' (Schinkel and Noordegraaf, 2011), whereby the actual content of work remains secondary. Taking my point of departure in this understanding of professions, Bourdieu's conceptualization of the symbolic order and his little used concept of ethos guide my analysis of professional boundary struggles.

Bourdieu's (1996) concept of field is used as an analytical starting point from which I develop an understanding of the nature of these struggles. The field designates a social microcosm and a historical space, where groups, individuals and institutions are directed at something – a core interest of the field. When occupational groups struggle for recognition and power it refers to an interest in defining the differentiating characteristics of professional practice (Bourdieu, 1989, Bourdieu, 1996, Schinkel and Noordegraaf, 2011). Interest hinges on capital, understood as that which has particular value in a field. Capital works by investing its members with power, 'like aces in a game of cards' and awarding them a particular position in the field. The capital efficient in a field appoints the structuring principles for the field's groupings because capital creates relations of proximity and distance between agents (Bourdieu, 1985, p. 724). Professional capital surfaces as relational distance created through relational properties i.e. of differences, gaps and distinctive features that exist in their relation to other properties (Bourdieu, 1985).

Professional capital materialises, for example, as advantageous wages (economic capital), the use of specialised knowledge (cultural capital) in practice and the possession and use of power. Importantly, capital relates to the communicative and symbolic representations of professional ability and difference (Bourdieu, 1991). The symbolic order concerns how the social is evaluated and classified and how beliefs about the world come to constitute the world (Bourdieu, 1989). For Bourdieu (1985, 1989), representations about the world create the world with social consequences. Discourse may thus legitimize an occupational group as a profession because the group is believed in as a profession and thus believed to possess the 'required' professional capital (Schinkel and Noordegraaf, 2011). Hence, professional boundary struggles concern the power to convince the world of the naturalness of the fact that an occupational group performs certain tasks and not others, and thus to conceal that the delegation of tasks and authority is often arbitrary. Moreover, they concern the efforts to convince that world that things could be different. Bourdieu (1991) sees language and discourse as always tied to a habitus and a position and practical experience in a field. Language is thus closely tied to the social structures that regulate a field and contributes to their formation and reformation.

Returning to the field concept, professional groups struggle to carve out privileged positions for themselves in what can be conceptualized as the healthcare field (Bourdieu, 1985, Collyer, 2018, Schinkel and Noordegraaf, 2011). The healthcare field is nested in the greater macro 'field of power' (Bourdieu and Wacquant, 1992, pp. 114 - 115) that structures the healthcare field, for example through reform. It means that to understand the logics that regulate professions and professionalisation, we must understand the forces of power that define what can take place in the field or 'the space of possibles' (Bourdieu, 1996, pp. 235 - 236), which I construct and analyse as 'the space of possible professionalisation'.

Professional ethos is part of the symbolic constructions active in a field, consisting of silent and self-evident truths of the field (Bourdieu, 1977, Emmerich, 2018). Bourdieu connects it with the concept of habitus, seeing habitus as encompassing ethos. Habitus is dynamic as 'an open system of dispositions', resulting from learning and socialization, for example, through education (Bourdieu and Wacquant, 1992, p. 133). Habitus is relevant for understanding how immersion into a particular professional milieu produces particular dispositions, perceptions and ways of acting that work as the foundation of a professional ethos (Bourdieu, 2003). Being part of habitus, ethos connects to both disposition and position in a field and thus to interest, ideology, power and capital. Moreover, ethos has a reflexive dimension that is used strategically by the professions and their educational institutions and associations to inculcate identity, normative ideas of right and wrong as well as professional differentiation (Abbott, 1988, Bourdieu, 1993, Emmerich, 2018).

Methodology

In order to empirically capture the complex relationship between field transforming forces and nurses' and doctors' boundary struggles, the study draws on different qualitative data.

First, the data are drawn from a larger ethnographic study in a Danish acute care department and includes 118 hours of participant observations of 25 nurses and nine doctors. The professionals were followed in their ordinary activities and observations included meetings in the department. The epistemological orientation informing the ethnography was that the research relationship is fundamentally social in nature (Bourdieu and Wacquant, 1992), meaning that I participated in work to the extent possible and conversed with staff during observations. All observations were recorded in situ as jottings that were written up in more coherent research accounts after the day's fieldwork (Emerson et al., 1995). In addition, I had privileged access to the hospital

intranet, which allowed me to read internal newsletters, local policies and employee magazines. The study was conducted over 13 months from 2013 to 2014 in cycles of different intensity over the year, and was concerned with the implications of care reorganization initiatives. The department is one of 21 recently established acute departments in Denmark, spearheading recent reform initiatives.

(see also Ernst, J. & Jensen Schleiter, A. (2019)).

Second, I collected secondary data concerning professional boundary struggles and related topics such as task delegation (Maier et al., 2017). A large body of textual material includes online forums, research articles, tweets, employee magazines and newsletters as well as articles from professional journals such as the Journal Sygeplejersken by the Danish Nurses Organisation (DNO). Bourdieu's concept of field devices an empirical sensibility towards the history and context of studied phenomena. Commenting on the dynamics of fields he states 'The direction of change depends on the state of the system of possibilities […] inherited from history. It is these possibilities which define what is possible or not possible to think or do at a given moment in any determined field' (Bourdieu, 1996, p. 206). Hence, to gain an understanding of the changing conditions for professionalisation and boundary drawings, I read research articles that could inform me of the history of the professionalisation projects of nurses and doctors as well as white papers, white books, policy agendas and national and regional strategy papers.

The following analysis is organised according to the two major themes that resulted from an iterative movement between theory and data (Saldaña, 2013). The first focuses on boundary struggles between nurses and doctors. The second concerns nursing internal boundary struggles, where battles between curing and caring ethos is an underlying and cross-cutting theme that points toward the constituents of change. Hence, when connected to Bourdieu's theoretical ideas, knowledge associated with

caring and curing emerged as fertile for demonstrating recent important developments in the space of possible professionalization and in day-to-day practice.

The history of medical and nursing professionalisation and ethos

Medicine

Medicine developed as a distinctive profession on the basis of rational science in opposition to the church and the powers of religion in the pre-enlightenment period (Pinell and Jacobs, 2011). The use and production of scientitfic knowledge marked the beginning of a movement from particularistic treatment to universalistic procedures, which increasingly rejected beliefs in the supernatural and the healing powers of nature (Pinell and Jacobs, 2011). A professional ethos developed that gained symbolic signficance in distinguishing doctors from quacks (Timmermans and Kolker, 2004). Emmerich (2018) suggests that we can talk about a particular curative ethos inspired by the Hippocratic tradition that has come to dominate the profession, but is variously realized in the medical specialties. The dominant understanding is that the doctor combines technical skill and scientific knowledge with a moral sense in the service of the patient (Abbott, 1988). Medicine was the first health occupation to professionalise and took charge of the hospitals as part of its professionalisation strategies. From this power base, it came to dominate the space of possible professionalisation for all other health occupations (Abbott, 1988, Currie et al., 2012).

The professionalisation of medicine gained speed and force with the development of evidence-based medicine (EBM) (Broom and Adams, 2012, Timmermans and Kolker, 2004). Combined with a societal appetite for more secure care, evidence-based medicine provided a space for doctors to form as a group that can keep its members in check by reference to universal scientific knowledge. The belief in evidence-based scientific knowledge gained the status of doxa (Bourdieu, 1977), meaning that it is regarded as unquestionable, which refers it to the domain of the

symbolic and allows it to work as capital in the field (Noordegraaf and Schinkel, 2011, Timmermans and Kolker, 2004).

Nursing

While the medical profession has been successful in convincing the world that it deserves the coveted status of profession, the professional status of nursing is relatively weak, and nurses must continuously defend their right to be classified as a profession and not as a semi-profession as is common (Abbott, 1988, Wicks, 1998). Nurses are united in their struggles to gain recognition of nursing as a profession yet, they are divided in terms of how professionalization, and thus professional legitimacy, should be obtained (Betts, 2009, Chua and Clegg, 1990, Taylor and Allen, 2007). The division is old, having its historical references to Florence Nightingale who established nursing as a two-tiered discipline. The 'lady nurses', rising to matrons, were recruited from the upper and middle classes and were better educated. They should oversee the work of the nurses ('probationers') who were recruited from peasants and domestic servants to do the practical work of caring for patients and cleaning the wards. Referred to as the 'head-hands' hierarchy it connoted a division of nursing based on those who used their heads in practice and those who used their hands (Chua and Clegg, 1990, Martinsen, 1978).

Nursing professionalization processes and struggles thus have a long history and vary with national context. However, the division outlined seems to persist and exist across national boundaries. Fundamentally, it concerns how work tasks and nursing roles are connected to forms of knowledge in practice, and how forms of knowledge may establish believed-in representations of what nurses are proficient of (Apesoa-Varano, 2007, Betts, 2009, McMurray, 2011, Traynor, 2009).

Broadly, we can speak of two strands within nursing defined by two nursing ethos, building on different forms of knowledge that can be assessed as endpoints on a continuum (Baumann et al., 1998). What is often termed caring in the

literature defines the traditional approach to nursing that links it to its foundation as a practical discipline that assisted the discipline of medicine (Apesoa-Varano, 2007, Betts, 2009, Chua and Clegg, 1990, Martinsen, 1978, Wicks, 1998). Caring takes pride in its focus on the basic care for patients and patient proximity (Apesoa-Varano, 2007, Baumann et al., 1998, Betts, 2009, Martinsen, 1978) and links nursing to a variety of theories and models that claim to take their outset within a humanistic perspective (Apesoa-Varano, 2007). However, in step with the increasing influence of the evidence-based movement, nursing has increasingly sought to academicize itself by becoming 'clinical' (Chua and Clegg, 1990, McMurray, 2011, Salhani and Coulter, 2009, Traynor, 2009). Traynor (2009, p. 499), for example describes how the promotion of evidence-based practice in nursing resulted from a persistent promotion of 'research- mindedness' as opposed to 'traditions, myths and rituals'.

Thereby, nursing has attempted to move from vocation to profession in accordance with the social and symbolic understandings of professionalism that characterize the field presently and which relies on theoretical knowledge (McMurray, 2011, Salhani and Coulter, 2009, Schinkel and Noordegraaf, 2011, Yam, 2004). What we may term curing defines nursing as a discipline performing an expanded scope of practices that leads to cure (Apesoa-Varano, 2007, Carney, 2016, Ernst, 2016, Salhani and Coulter, 2009). Curing relies on new nursing tasks that are scientifically grounded, resting on the evidence-based knowledge system of medicine and so, it associates with important professional capital in the field (Betts, 2009). The curing ethos can thus be seen as a response to the development in field, where politicians endorse professional flexibility and 'secure', quantifiable approaches to practice in pursuit of quality, safety and efficiency improvements.

Field dynamics and boundary struggles

In the coming section, it is demonstrated how the described development has triggered new boundary dynamics and struggles between the nursing and medical professions as well as internally in nursing.

Curing – encroaching on medicine?

The curing ethos emphasizes the nurse as a clinical expert who can act and make decisions related to diagnosis and treatment independently of doctors, although to varying degrees. In the coming, we see how the emergence of curing-oriented nursing in the shape of Advance Practice Nurses (APN) and Acute Care Nurses respectively triggers new boundary struggles. Both groups work at the interface of the traditional nursing and medical professions (Maier et al., 2017, McMurray, 2011) and are constructed as the solution to structural problems in healthcare such as medical staffing shortages and care disintegration (Bech, 2017, King et al., 2015, Warwick-Giles and Checkland, 2018). The first part of the coming concerns APN and the second part Acute Care Nurses.

In a recent OECD report, "A Nurse Practitioner/Advanced Practice Nurse is a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice […]. A Master's degree is recommended for entry level" (Maier et al., 2017, p. 15). APN education is relatively common internationally, and in an ascending trend, but not yet available in all OECD countries. In Denmark, the education was established on a pilot basis, beginning in the autumn of 2019 (Maier et al., 2017, Pinborg, 2017). The DNO had for long argued for the potential advantages of advanced nurses and was ultimately successful in their efforts. The head of the organisation stated in a news release:

> The new type of nurse will, briefly stated, benefit both citizens and the national economy […]. With the great shortage of doctors and a health system on the verge of meltdown, the new nurses are extremely important.

> They have additional competences and will have a central coordinating role in care that enables them to provide much needed help in the struggling Danish health system. They can lay the foundations of a new development in the sector of creating a better outlook in care and furthering cross-professional collaboration. (Bech, 2017, p. 2, author's translation).

The except shows how the DNO uses refences to current crisis discourse in the field to forward their interests and position APN nurses as providing solutions to societal problems. In this, it is emphasised how the jurisdiction and scope of work for these nurses are different and needed by the health system because they can do more than traditional registered nurses. The APN programme appeals to an ambitious nursing habitus that has an appetite for task delegation, which affiliates APN nursing with medicine and evidence-based knowledge as efficient capital.

Task delegation is only indirectly mentioned by the DNO in the news release and the issue is conflict triggering. This is illustrated in the following dialogue on Twitter, where the DNO announces the advent of the APN education. The excerpt reveals the considerable expansion in professional capital, which the new education carries with it and thus the education's symbolic value for the profession.

> Historic breakthrough for Danish healthcare: Denmark will have a new type of nurses. Eight Danish municipalities write history by establishing an advanced nursing education in accordance with international standards. With the additional competences acquired, these nurses will come to play a key role in the Danish health sector.

To this the General Manager of the Danish Medical Association (DMA) responds by asking:

> Can nurses diagnose, prescribe medications and commence treatment?

The response by the General Manager seems aggressive since the DNO does not mention prescription and treatment in the tweet. It unveils that the nurses' claim to an expanded role in practice cannot straightforwardly be granted by the medical profession, and that these two task areas are part of core clinical capital of exclusive ability that needs protection up front.

Clearly affected by the heads-on confrontation and in an act of reaching out to the medical profession, the DNO now modifies the enthusiasm of the first tweet by reference to collaborative ties between the two professions and by allowing for the acquisition of such capital to take its time. In doing so, the organisation confirms their subordinate position in the hierarchy between the two professions.

> This is the ambition in the longer run. In the project, we build on existing good collaboration, mentoring etc.

However, this is seemingly not appeasing the DMA since the tweet triggers another rebuff by the president of the association, confirming that the APN nurses and the associated task delegation are perceived as boundary threats by the doctors:

> Diagnosis and medicine ordination are medical tasks for undisputed professional reasons. (Twitter, @Sygeplejeraadet, 6 - 7 Nov. 2017, author's translation).

The prompt and direct responses by the medical spokespersons indicate that much is at stake for the medical profession whose primary concern is to preserve the status quo, where nurses and doctors 'know their places' in the work hierarchy and doctors are the only legitimate clinical experts (Currie et al., 2012). The struggle on Twitter was for both organisations an important political battle that concerned the future relational

constellation between nursing and medicine and resulted in a symbolic affirmation of the professional hierarchy.

Another new and relatively autonomous nursing role is that of acute care nursing. The role is designed to improve the flow of care and seen as essential for improving patient experience and care efficiency in acute care departments and the entire hospital organisation (Kirk and Nilsen, 2016, Norris and Melby, 2006). Acute care nurses have received additional training and are expected to stay updated with the most recent research evidence, performing evidence-based practice (Kirk and Nilsen, 2016). In Denmark, acute care departments are spaces for the materialisation of political ambition and goals concerning flexible professional roles in care (Ernst, 2017). This renders them spaces of professional opportunity for nurses who are not afraid of embarking on a new curing-oriented role. A nurse in a group interview, performed in the acute care department, stated that 'we are in many cases able to work on a par with doctors'. Several of these nurses' tasks result from the delegation of tasks from doctors to nurses. In the following excerpt from the Journal Sygeplejersken by the DNO, a nurse expresses how task delegation is related to evidence-based knowledge, and how she sees this as implying an extra responsibility toward colleagues.

> Besides ensuring that the traditional nursing tasks performed here are evidence-based, I also think that we, together with the doctors, are responsible in ensuring the evidence behind new tasks. That also provides opportunities for development. (Tram, 2017, p. 27, author's translation).

The excerpt is illustrative of the capital at stake in the changed relation to colleagues with a division between traditional and new tasks. However, again, and in line with the findings of other commentators (Currie et al., 2010, McMurray, 2011, Norris and Melby, 2006), the enthusiasm for more independent nursing roles is not always shared by the doctors. In the following, specialist doctors in the acute care department explain

how they feel that the nurses have become too ‘posh’ because they resist catering for the doctors.

> The nurses here reject the traditional hierarchical role distribution. They refuse catering for us because they are treatment nurses and think they can manage care by themselves. The problem is that we have to intervene time and again. (Specialist doctor 1, fieldnotes).

Treatment nursing refers to orthopaedic specialisation, which some of the nurses have acquired. Apparently, the subject of catering for is sensitive in day-to-day dialogue between nurses and doctors and the way collaboration is discursively constructed in the department becomes a topic of reflection and careful consideration:

> When we discuss the role problematic with the nurses, we must be careful not to address it with terms like “cater for” or “role assignment”, but rather talk about “optimization of work organization” or something like that. You know, often the problem concerns really mundane things like having the equipment ready for us when we need it. (Specialist doctor 2, fieldnotes).

Besides emphasising the capital related to acute care nursing, the excerpts demonstrate how the nurses’ rejection of traditional professional role relations can also be seen as a rejection of the historically gendered relation between doctors and nurses, where doctors have traditionally been male and nurses female, and where it seems only natural that nurses perform a form of catering or ‘mothering’ for patients and doctors (Apesoa-Varano, 2007, Wicks, 1998). By thus claiming new expertise and tasks and resisting traditional understanding of what nurses and doctors can and should do, nurses informed by the curing ethos ‘stir the pot’ of the professional hierarchy.

Curing – driving out caring?

The focus on care managerialism, science and evidence-based practice, enveloping nursing professionalisation opportunities, has brought the caring ethos under pressure, and differentiation and stratification among nurses are accentuated. The values and ideas of craft, altruism and holism that identify the caring ethos (Baumann et al., 1998) are confronted with the scientific 'facts' that pre-dominantly undergird the curing ethos as expressed by a curing oriented nurse in the following.

> The good thing about triage is that it is hardcore facts. I am not supposed to believe or think anything. (Hospital employee magazine, author's translation).

Triage is the standardised admittance of patients based on acuity level. Nurses informed by the curing ethos often struggle to convince their caring oriented colleagues of the virtues of evidence-based and standardized practice because care can only to a limited extent or not at all be standardized and counted according to the ethos of caring (Baumann et al., 1998). This is expressed in the following by a nurse in an article published in Sygeplejersken.

> There are those who think that the inner nature of nursing is so unique that it cannot be quantified. To me, it sounds like nonsense. Because, of course, we can measure the care we provide to our patients. It depends solely on the problem at hand (Kjærgaard, 2004, p. 8, author's translation).

The excerpts are illustrative of how the curing ethos constructs a symbolic distance to the caring ethos by reference to 'hardcore facts' as opposed to 'believing' or 'thinking', where facts are seen to serve the patients best.

The craft aspect is fundamental to the care ethos, which is referred to by the idea of the 'clinical gaze' or 'clinical judgement'. The clinical judgement rests on

the idea of skill acquisition and experiential learning outcomes where the nurse's competence gradually increases, enabling appropriate situational responses in practice as part of the embodied nursing habitus (Benner, 2004, See also Ernst and Jensen Schleiter, 2018). The belief in craft is illustrated below, where a nurse in the acute care department criticises the heavy reliance on standards in the department:

> You know, before we got the triage system, we assessed our patients too. We did it on the basis of our experience and our clinical gaze and it worked perfectly well. In many cases I would say it worked better. (Fieldnotes).

The nurse thus draws directly on a well-known nursing discourse that symbolically constructs the nurse as connected to the patient through embodied craft, which is the essence of professionalism, according to this ethos. The caring ethos defines good nursing as incompatible with the narrower positivistic ideals of evidence-based practice and caring-oriented nurses are critical of care efficiency that is seen to result in briefness and haste, hindering good patient contact. This topic was debated in a nursing meeting in the acute care department, which the author observed:

> Nurse 1: When I asked a patient yesterday how she felt, she told me I was the first to ask her that question.
>
> Nurse 2: Have we become so busy with the MUST DO things that we forget to communicate with our patients? All the time we articulate what must be remembered and measured, but we never articulate the soft values of nursing that are stated in the nursing frame of reference. Shouldn't we articulate the soft values more? […]. We should articulate that our patients need attention, kindness, care. We must challenge the idea that everything

> can be justified with reference to numbers and hard values. (Fieldnotes, emphasis added).

The excerpt shows how the nurses construct nursing as moral issue of treating the patients right according to the criteria embedded in the caring ethos, which is here referred to by the nursing frame of reference. The struggle between curing and caring essentially becomes a struggle between the qualitative and 'soft' and the quantitative and 'hard'. Yet, there is too an element of caring being pressured by the curing ethos. The caring ethos is squeezed because other logics emphasizing care accountability, efficiency and professional flexibility occupy and structure the field.

Discussion and conclusion

Professional boundary struggles have for long attracted attention in the research literature. This paper suggests a novel understanding of boundary struggles through Bourdieu's relational and multi-layered sociology and his concept of ethos and the symbolic order. The paper focused on the emergence and development of boundary struggles at multiple layers of the Danish hospital field. Central to the analysis was nurses' attempts at professionalisation through an expanded scope of practice when they embark on what was conceptualised as a curing ethos that understands nursing as a discipline performing practices that lead to cure (Salhani and Coulter, 2009). The emergence and increasing force of this ethos has hitherto not been analysed in the literature (However, see Ernst, 2016). My construction of what I term 'the space of possible professionalisation' is predicated on Bourdieu's (1996) field concept, meaning that professionalization and boundary struggles are understood in a dialectical analytical movement between day-to-day practice of nurses, political struggles of associations and professional elites, and the definition of problems in the wider field that prompts an ideological re-orientation of healthcare. In a relational and symbolic perspective,

professions are defined and redefined in relation to each other and constituted through evaluation, classification and belief.

The analysis demonstrated that the constituents of the analysed boundary struggles can be understood in terms of five structuring factors: nurses' historical struggles for professionalization; the relation between nursing and medicine; the medical professions' attempts at defending their core capital; global developments and political concerns entailing, among others, the promotion of evidence-based knowledge and evidence-based practice and, finally, the nursing profession's internal division concerning ethos. I will elaborate on these factors below.

At the political level of professionalisation struggles, the Danish Nurses Organisation draws on established crisis discourse in the field when it suggests an expanded scope of nursing as a solution to structural problems in healthcare. In this way, the organization seeks to claim the opportunities for professionalisation that have emerged in the space of possible professionalisation. However, in relying on the delegation of clinical tasks that are associated with core medical capital, the categories of APN (Advanced Practice Nurse) and acute care nursing challenge core institutionalised beliefs in what nurses and doctors can and should do. In challenging these doxas (Bourdieu, 1977), interdisciplinary struggles are activated regardless of the fact that task delegation is supported by policy (Maier et al., 2017, Tram, 2017). The delegation of tasks from doctors to nurses puts professional identity and position at stake by suggesting a relational redistribution of professional capital (Apesoa-Varano, 2007, Ernst, 2017). Capital redistribution is complex because it concerns the distribution of power between the professions and the symbolic value of the professional hierarchy. Professional power distribution refers to that which is arbitrary, taken for granted and concealed by traditional power structures in the field. In the data, the Danish Medical Association used their symbolic power to refer the nurses back in their 'right place' in a Twitter dialogue concerning the advent of the APN education in

Denmark. This was done with reference to nurses' lack of clinical expertise for 'undisputed professional reasons'; thus masking the political footing of their response to the nurses. However, and interestingly, prescription is recognised as part of APN expertise in other countries (Maier et al., 2017). Boundary struggles are thus structured by global forces yet, they unfold locally and are influenced by particular national forces.

The belief in scientific evidence, in particular, medical evidence-based knowledge is a global force of importance (Timmermans and Kolker, 2004). Translated into evidence-based practice it earns its force in offering a solution to quality and efficiency-related problems in healthcare (Broom and Adams, 2012). The perception of evidence as a 'remedy' is too found in the idea of evidence-based policymaking, which is spreading from public health to other areas (Triantafillou, 2015). The nursing curing ethos claims legitimacy through its affiliation with evidence-based practice and by offering a solution to medical staffing shortages. However, while being politically endorsed, the data demonstrates how the curing ethos is also confronted with obstacles at the level of practice.

In the acute care department, which is analysed as a local space of possible professionalisation, boundary struggles surface as role disagreements between nurses and doctors. The disagreements concern whether the nurses' supplementary education can justify their rejection of traditional collaborative roles, where nurses assist doctors. In this way, they are directly related to the political level of professionalization struggles. Moreover, boundary struggles surface in the department as 'ethos confrontation' between caring and curing oriented nurses. The paper thus draws attention to how boundary struggles is not solely an inter-professional matter but also concerns intra-professional boundary dynamics that relate to and may enlarge professional stratification.

The nurses informed by the caring ethos feel embattled by the curing ethos, which imposes evidence-based and standardised practice. We saw how the nurses

informed by the caring ethos counter the curing ethos by emphasising the embodied and craft-based aspects of nursing. While curing is siding with medicine by drawing on medical scientific knowledge, caring is 'a kind of antithesis to medicine' (Traynor, 2009, p. 502) that differentiates itself from curing and medicine by drawing on other forms of knowledge. The struggles can be said to reproduce the earliest 'head-hands' stratification of nursing (Martinsen, 1978). The difference from then to now is that where science was absent from both medicine and nursing earlier, it is now the core lever for professionalization. Evidence-based knowledge is thus used by the elite 'head' nurses to professionalise, leaving the 'hands' with the patients but with little professionalisation capital. Nevertheless, this should not lead us to understand the relation between caring and curing ethos in real life practice as purely binary. Nurses can use the full spectrum of caring and curing-oriented knowledge in practice, and nurses may navigate several positions in practice, which many should be expected to do (See, for example, Ernst, 2016).

The boundary struggles analysed in this paper raise important questions about healthcare manageability. Many current attempts at change to the sector concern attempts at encouraging workforce flexibility with the goal of achieving better and more integrated care flows (Huby et al., 2014, Warwick-Giles and Checkland, 2018). This is topical, for example, in regard to the large group of patients who have complex diagnoses that require professional coordination for successful treatment and care (Cramer et al., 2018). State level actors are thus engaged in attempts at redefining 'the space of possible professionalisation' to fit their needs. However, as Currie et al. (2010) put forth, policy makers fail to realise that healthcare professional roles and titles refer to deeply embedded social structures and hierarchies. The paper has demonstrated how political and managerial intentions are restrained or blocked by social dynamics that work outside the domains of rationalised discourse about care efficiency, quality and progress. Understanding the nature of boundary struggles is important for developing a

solid foundation for policy and management in healthcare. While the changes sketched in this paper are undoubtedly motivating for part of the health professional workforce, they represent deterioration for others. The development of sustainable professional environments is thus an interesting topic for future research.

Acknowledgements

I thank the reviewers for their time and constructive comments, the staff at the acute care department for their participation in my research and all colleagues who have provided their help and comments on drafts. Special thanks to Kristian Larsen and Karin Anna Petersen.

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References

Abbott, A. (1988). *The system of professions: An essay on the division of expert labor.* Chicago: The University of Chicago Press.

Apesoa-Varano, E. C. (2007). Educated caring: The emergence of professional identity among nurses. *Qualitative Sociology,* 30, 3, 249-274.

Baumann, A. O., Deber, R. B., Silverman, B. E. & Mallette, C. M. (1998). Who cares? Who cures? The ongoing debate in the provision of health care. *Journal of Advanced Nursing,* 28, 5, 1040-1045.

Bech, M. (2017). Danmark får en helt ny type sygeplejersker. dsr.dk: Dansk Sygeplejeråd.

Benner, P. (2004). Using the Dreyfus Model of Skill Acquisition to Describe and Interpret Skill Acquisition and Clinical Judgment in Nursing Practice and Education. *Bulletin of Science, Technology & Society,* 24, 3, 188-199.

Betts, C. E. (2009). Nursing and the reality of politics. *Nursing Inquiry,* 16, 3, 261-272.

Bourdieu, P. (1977). *Outline of a Theory of Practice.* Cambridge: Cambridge University Press.

Bourdieu, P. (1985). The Social Space and the Genesis of Groups. *Theory and society,* 14, 6, 723-744.

Bourdieu, P. (1989). Social Space and Symbolic Power. *Sociological Theory,* 7, 1, 14-25.

Bourdieu, P. (1991). *Language and Symbolic Power.* Cambridge: Polity Press.

Bourdieu, P. (1993). *Sociology in Question.* London: SAGE.

Bourdieu, P. (1996). *The Rules of Art.* Cambridge: Polity Press.

Bourdieu, P. (2003). Participant Objectivation. *Journal of the Royal Anthropological Institute,* 9, 2, 281-294.

Bourdieu, P. & Wacquant, L. J. D. (1992). *An Invitation to Reflexive Sociology.* Cambridge: Polity Press.

Broom, A. & Adams, J. (2012). A critical Social Science of Evidence-Based Healthcare. *In:* Broom, A. & Adams, J. (eds.) *Evidence-Based Healthcare in Context: Critical Social Science Perspectives.* Surrey, England: Ashgate Publishing Ltd.

Carney, M. (2016). Regulation of advanced nurse practice: its existence and regulatory dimensions from an international perspective. *Journal of Nursing Management,* 24, 1, 105-114.

Chua, W.-F. & Clegg, S. (1990). Professional Closure: The Case of British Nursing. *Theory and Society,* 19, 2, 135-172.

Collyer, F. (2018). Envisaging the healthcare sector as a field: moving from Talcott Parsons to Pierre Bourdieu. *Social Theory & Health,* 16, 2, 111-126.

Cramer, H., Hughes, J., Johnson, R., Evans, M., Deaton, C., Timmis, A., Hemingway, H., Feder, G. & Featherstone, K. (2018). 'Who does this patient belong to?' boundary work and the re/making of (NSTEMI) heart attack patients. *Sociology of Health & Illness,* 40, 8, 1404-1429.

Currie, G., Finn, R. & Martin, G. (2010). Role Transition and the Interaction of Relational and Social Identity: New Nursing Roles in the English NHS. *Organization Studies,* 31, 7, 941-961.

Currie, G., Lockett, A., Finn, R., Martin, G. & Waring, J. (2012). Institutional work to maintain professional power: recreating the model of medical professionalism. *Organization studies,* 33, 7, 937-962.

Emerson, R. M., Fretz, R. I. & Shaw, L. L. (1995). *Writing ethnographic fieldnotes.* Chicago: University of Chicago Press.

Emmerich, N. (2018). Leadership in palliative medicine: moral, ethical and educational. *BMC Medical Ethics,* 19, 1.

Ernst, J. (2016). Evidence-based nursing in the IED: From caring to curing? *Nordic Journal of Working Life Studies,* 6, S 1, 47 - 66.

Ernst, J. (2017). Between change and reproduction: Profession, practice and organizational space in a hospital department. *Journal of Organizational Ethnography,* 6, 3, 177-189.

Ernst, J. & Jensen Schleiter, A. (2018). Standardization for patient safety in a hospital department: killing butterflies with a musket? *Qualitative Research in Organizations and Management: An International Journal,* 13, 4, 367 - 383.

Ernst J and Jensen Schleiter A (2019) Organizational Identity Struggles and Reconstruction During Organizational Change: Narratives as symbolic, emotional and practical glue. *Organization Studies* 0(0): 0170840619854484.

Evetts, J. (2013). Professionalism: Value and ideology. *Current Sociology,* 61, 5-6, 778-796.

Faulconbridge, J. R. & Muzio, D. (2012). Professions in a globalizing world: Towards a transnational sociology of the professions. *International Sociology,* 27, 1, 136-152.

Huby, G., Harris, F., Powell, A., Kielman, T., Sheikh, A., Williams, S. & Pinnock, H. (2014). Beyond professional boundaries: relationships and resources in health services' modernisation in England and Wales. *Sociology of Health & Illness,* 36, 3, 400-415.

Jespersen, P. K. (2013). Quality development and professional autonomy in modern hospital fields. *In:* Teelken, C., Ferlie, E. & Dent, M. (eds.) *Leadership in the Public Sector: Promises and Pitfalls.* Oxon: Routlegde.

Jones, L., Fraser, A. & Stewart, E. (2019). Exploring the neglected and hidden dimensions of large-scale healthcare change. *Sociology of Health & Illness,* 41, 7, 1221-1235.

Kessler, I. & Spilsbury, K. (2019). The development of the new assistant practitioner role in the English National Health Service: a critical realist perspective. *Sociology of Health & Illness,* 41, 8, 1667-1684.

King, O., Nancarrow, S. A., Borthwick, A. M. & Grace, S. (2015). Contested professional role boundaries in health care: a systematic review of the literature. *Journal of foot and ankle research,* 8, 1, 2-2.

Kirk, J. W. & Nilsen, P. (2016). Implementing evidence-based practices in an emergency department: contradictions exposed when prioritising a flow culture. *Journal of Clinical Nursing,* 25, 3-4, 555-565.

Kjærgaard, G. (2004). Som at vende en supertanker. *Sygeplejersken / Danish Journal of Nursing,* 23, 8 - 9.

Maier, C., Aiken, L. & Busse, R. (2017). Nurses in advanced roles in primary care - policy levers for implementation. OECD Health Working Papers. OECD, Organisation for Economic Co-operation and Development.

Martinsen, K. (1978). Fra ufaglært fattigsykepleie til profesjonelt yrke—Konsekvenser for omsorg. *In:* Persson, I. B., Ravn, K. & Truelsen, R. (eds.) *Fokus på Sygeplejen.* København: Munksgaard.

Mcdonald, R. (2014). 'Bourdieu', medical elites and 'social class': a qualitative study of 'desert island' doctors. *Sociology of Health & Illness,* 36, 6, 902-916.

Mcmurray, R. (2011). The struggle to professionalize: An ethnographic account of the occupational position of Advanced Nurse Practitioners. *Human relations,* 64, 6, 801-822.

Nancarrow, S. A. & Borthwick, A. M. (2005). Dynamic professional boundaries in the healthcare workforce. *Sociology of Health & Illness,* 27, 7, 897-919.

Noordegraaf, M. & Schinkel, W. (2011). Professional capital contested: A Bourdieusian analysis of conflicts between professionals and managers. *Comparative Sociology,* 10, 1, 97-125.

Norris, T. & Melby, V. (2006). The Acute Care Nurse Practitioner: challenging existing boundaries of emergency nurses in the United Kingdom. *Journal of Clinical Nursing,* 15, 3, 253-263 11p.

Pinborg, K. (2017). Otte kommuner udvikler ny uddannelse til sygeplejersker. [Accessed 27 March 2017].

Pinell, P. & Jacobs, A. (2011). The Genesis of the Medical Field: France, 1795-1870. *Revue française de sociologie*, 5, 117-151.

Saldaña, J. (2013). *The Coding Manual for Qualitative Researchers.* Los Angeles: SAGE Publications Ltd.

Salhani, D. & Coulter, I. (2009). The politics of interprofessional working and the struggle for professional autonomy in nursing. *Social Science & Medicine,* 68, 7, 1221-1228.

Schinkel, W. & Noordegraaf, M. (2011). Professionalism as Symbolic Capital: Materials for a Bourdieusian Theory of Professionalism. *Comparative Sociology,* 10, 1, 67-96.

Taylor, S. & Allen, D. (2007). Visions of evidence-based nursing practice. *Nurse researcher,* 15, 1, 78-83.

Timmermans, S. & Epstein, S. (2010). A World of Standards but not a Standard World: Toward a Sociology of Standards and Standardization. *Annual Review of Sociology,* 36, 1, 69-89.

Timmermans, S. & Kolker, E. S. (2004). Evidence-Based Medicine and the Reconfiguration of Medical Knowledge. *Journal of Health and Social Behavior,* 45, 177-193.

Tram, E. (2017). Opgaveflytning vinder nyt land. *Sygeplejersken,* 12, 22 - 29.

Traynor, M. (2009). Indeterminacy and technicality revisited: how medicine and nursing have responded to the evidence based movement. *Sociology of Health & Illness,* 31, 4, 494-507.

Triantafillou, P. (2015). The Political Implications of Performance Management and Evidence-Based Policymaking. *The American Review of Public Administration,* 45, 2, 167-181.

Warwick-Giles, L. & Checkland, K. (2018). Integrated care: Using "sensemaking" to understand how organisations are working together to transform local health and social care services. *Journal of Health Organization and Management,* 32, 1, 85-100.

Wicks, D. (1998). *Nurses and doctors at work. Rethinking professional boundaries.* Buckingham: Open University Press.

Yam, B. M. C. (2004). Professional issues. From vocation to profession: The quest for professionalization of nursing. *British Journal of Nursing,* 13, 16, 978-982.